Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E183		B. WING		08/19/2	014	
GOVE COUNTY MEDICAL CENTER LTCU PO			РО ВО	RESS, CITY, STATI (129 ER, KS 67752			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3		F 000			
		ns represent the findings I Complaint Investigatio 7190, #77193.					
	483.20(g) - (j) ASSES ACCURACY/COORE	SSMENT DINATION/CERTIFIED		F 278			
	The assessment must resident's status.	st accurately reflect the					
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.		te				
	A registered nurse must sign and certify that the assessment is completed.		the				
		completes a portion of t gn and certify the accura sessment.					
	willfully and knowingle false statement in a resubject to a civil mone \$1,000 for each assess willfully and knowingle to certify a material and statement of the statement of th	Medicaid, an individual ly certifies a material an resident assessment is tey penalty of not more essment; or an individually causes another individual false statement in a is subject to a civil morhan \$5,000 for each	d than I who dual				
	Clinical disagreemen material and false sta	at does not constitute a atement.					
	The facility had a cer sample included 17 r review and interview,	not met as evidenced business of 34 residents. The residents. Based on recount to the facility failed to	e ord		TITLE) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		17E183		B. WING		08	/19/2014
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU			РО ВОХ	ESS, CITY, STATE (129 ER, KS 67752	, ZIP CODE	·	
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F 280 SS=E	accurately assess and assess (Resident #16 for vivil Findings included: Resident #16 for vivil Findings included: Resident #16's quantity set 3.0 assessment resident scored 9 for Mental Status, vivil cognitive impairmed assistance of 1 states Daily Living. The Mind Weighed 133# (pout or more in the last mechanically altered The quarterly MDS unchanged except Review of the med resident's weight of 7/28/14-133# (prior 5/9/14-130# (prior 5/9/14-14-130# (prior 5/9/14-14-130# (prior 5/9/14-14-130# (prior 5/9/14-14-130# (prior 5/9/14-14-130# (prior 5/9/14-14-14-14-14-14-14-14-14-14-14-14-14-1	uarterly (MDS) Minimum at, dated 8/6/14, indicated on the (BIMS) Brief Intervention (ADLs) Activition (ADLs) Activition (ADLs) Activition (ADLs) Activition (ADLs) Activition (ADLs) Activition (ADLs)	Data the lew es of t of 5%	F 280			
35=E	The resident has the incompetent or oth	ne right, unless adjudged					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF D PLAN OF CORRECTION IDENTIFICATION NUM		LIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	17E183			B. WING		08/19/2014	
GOVE COUNTY MEDICAL CENTER LTCU PO			РО ВОХ	ESS, CITY, STA (129 R, KS 6775			
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F 280	participate in planning changes in care and A comprehensive car within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent prathe resident, the resident, the resident in the r	g care and treatment or treatment. e plan must be develop	ned nding ility n leeds, on of dent's ed	F 280			
	The facility had a cen sample included 17 robservation, interview facility failed to revise residents. (#39 regardurinary catheter, #32 regarding the level of (ADLs) Activities of D. Findings included: - Resident #39's adm Data Set 3.0 assessmindicated the resident memory problems, see making skills and acum MDS indicated the reassistance for (ADLs)	isus of 34 residents. The esidents. Based on wand record review the the care plan for 4 of 1 ding feeding tube and and #9 regarding falls, is taff assistance require raily Living. Inission (MDS) Minimum nent, dated 6/23/14, thad short/long term everely impaired decision the mental changes. The sident required total state () Activities of Daily Livinger and no tube feeding.	#4 ed for on e aff				

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	OVIDER OR SUPPLIER UNTY MEDICAL CEN	TER LTCU	РО ВО	RESS, CITY, STA X 129 ER, KS 6775				
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F 280	received antibiotic methods period. Review of the medical re-admitted the reside 7/16/14, with a feeding in place. The 7/16/14 care plan resident's feeding tub. The 7/16/14 physician included Jevity (liquid (cc) cubic centimeters resident's feeding tub lacked any other instrated feeding tube. The phy urinary catheter due to obstruction. On 7/17/14 at 9:40 Al resident in bed with the approximately 30 deg drainage bag attached observation revealed medication to the resifeeding tube. Nurse Leflush, 80 cc Arginaid (12 gram protein drink tube with 30 cc of wat on 7/22/14 at 7:30 Al stated the admitting in care plan intervention needs of the resident had not updated the cor instructions for the which included a feed	I record revealed the fact from the hospital, or g tube and urinary cather and urinary cather. It is admission orders nutritional supplement is, four times per day, vie. The physician's order uctions for the care of the ca	acility neter or the), 250 a the ars the d a y d the ated neter ther ent's r with a ng e A initial aff cons atus, y	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
	and Plan of Correction identification now			B. WING		08/19/2014		
						08/1	9/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
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			QUINTE	IN, NO 0113				
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F 280	Continued From page	e 4		F 280				
	feeding directed the n placement in the ston confirmed, use a 60 c water to flow into the	policy for abdominal tub nurses to confirm tube nach and, after placeme cc syringe, allow 30 cc o tube to establish paten ding, flush the tube with	ent is of cy,					
	The facility failed to revise the care plan for Resident #39, who was re-admitted to the facility with a urinary catheter, a feeding tube, and was not to receive anything by mouth, per the physician's orders.							
	Set 3.0 assessment, or resident had severely (BIMS) Brief interview 5. The MDS indicated moderately impaired had wandering and withe look back period. independent with (AD including walking and Range of Motion impact The resident's balance walking, he/she had 1 scheduled pain medical	vision, wore glasses an erbal behaviors 1-3 day The resident was ILs) Activities of Daily L transfers, had no (ROI airment and used a wal	the n a re of d rs of iving W) ker.					
	back period. The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 4/23/14, indicated the same except a BIMS of 6, independent with bed mobility, transfers, walking, but required limited assistance with toileting. The resident's balance was unsteady but he/she was able to stabilize him/herself and had 1 non-injury fall.		ed nce					

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR		TE, ZIP CODE			
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F 280	Continued From page The 7/16/14 quarter except BIMS 4, physically, rejected care as MDS indicated the massistance with dress bed mobility, transfer more non-injury falls since the prior MDS and diuretic medicated. The 2/6/14 (CAA) Commany for falls prior to this past quarter on indicated the resident bathing but was other than the resident bathing but was other than the falls for trend on and clean, ensure footwear and the encare plan updates in resident to toilet ever 4/10/14 -assist the reduring the night shift transfers, ambulation light was already on encourage the resident not on the sofa.	ly MDS indicated the satisfical, verbal behaviors 1 and wandering 4-6 days esident required extensising, limited assistance irs, walking, toileting, hard, 2 or more minor injury, and received antidepresions 7 days. The Area Assessment dicated the resident had to admission and had on 1-13-14. The CAA for Ant required assistance werwise fairly independent an for falls directed the sanight light in his/her room to get up slowly, analyzeds, ensure his/her eye gle the resident wears provironment is free of clutt included: 4/6/14 - assist iry 2 hours while awake. esident to toilet at least of the table of the care plan. 5/8/14 - ent to nap in his/her room 5/25/14 - ensure call lig	-3 . The ve with d 2 or falls ssive a le fall DLs ith tt. ttaff to n, e asses per er. tthe once night m	F 280				
	resident to stand slo plan. The 7/6/14 upo room free of clutter v 7/22/14 - try to get h	2/14 update of cue the wly was already on the date to ensure the reside was already on the care im/her to go to the dinin 3/14 care plan for falls w	ent's plan. g					

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F 280	The 7/23/14 care plaindicated the resident progressing and the The resident had a fix staff tried to walk with and a (FWW) front with became upset. The resident experience quarter and two of the trauma. The resident a pressure pad alarm slept during the night assistance with several the staff found the resident sevents of the fall, defended the with several the	an conference summary ont's dementia was rapidly resident's family was averally esterday and now the him/her using a gait by wheeled walker, but he/s summary indicated the dimultiple falls this past the falls resulted in head at resisted care at times, m, but hated it, he/she had needed extensive eral ADLs. I score of 12 indicated the for falls. (10 or more The 4/29/14 fall risk score all risk score of 20 indicated the for falls was increasing. PM, fall investigation indicated the floor and slipped and the floor and slipped ent was able to report the enterthal pain and had no injury. All investigation indicated the recliner. The resident sitting on the floor and the floor and slipped enterthal e	vare. vare. ne elt he had ardly e re of ated cated s/her d in e itury. cated or in dent as The is and	F 280			

	F OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ DF CORRECTION IDENTIFICATION NUMBER		LIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 280	the resident slept on room and when the shim/her to sit up, the assistance, to the florencouraged the resident rest in the recline. The 5/29/14 at 5:50 fithe staff found the rethe floor, without injuiting was covered with a brunder his/her head. The floor next to extended outward. The 6/23/14 at 12:21 summary indicated the sitting on floor next to extended outward. The resident was not weat and socks on and laut playing hide and see scratches to the resident was not weat and objects in the resident distance of the staff of the staff distance o	the couch near the dinitiatiff attempted to assist resident slid, with staff or without injury. Staff dent to go to his/her rooter or bed when sleepy. PM, fall investigation included in the plan was to continuous. The note indicated halanket and had a cushion the plan was to continuous. PM, fall investigation he staff found the resident the closet with his/her the summary stated the uring pants but had show a ghed and stated he/show. The staff noted 3 dent's mid back which	m dicted on lee/she on lee/she on lee the legs les e was liture les did did did did did did did did did di	F 280			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 280	medication) at 9:40 A investigation stated s to the (ER) emergence assessed a subcutan hematoma (pooled bit The investigation statincluded, after adminishe resident frequentithe call light for trans. The 7/6/14 ER report remained conscious appropriately, had a his/her head and a 2 bleeding. The scalp lapalpation indicated a The 7/22/14 at 10:00 the staff found the reshis/her bathroom in fiskin tear to his/her m stated he/she hit his/liskin tear was closed an ice pack. The note resident did not like a alarm would be applied on 8/5/14 at 12:36 President got up from a staff person went to him/her with ambulat his/her room. Further resident had scabbed and one pink colored cm long at the top of On 8/6/14 at 8:56 AM resident independent from the dining room	M for hip pain. The staff transported the resicy room and the physici deous (under the skin) lood) at the laceration sted corrective actions istering Percocet, checkly and encourage the usfers. It stated the resident, whand answered questions of the composition of the total composition of the t	an ite. k on se of so pp of with and ma. ated or in se om and the sied shall distributed and the sead sely 3 the selker and	F 280			

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00.200		12.12.00		ER, KS 6775	52			
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F 280	Continued From pag	e 9		F 280				
	ambulated about 10 f he/she went back for slight limp at a moder observation no staff v On 8/7/14 at 1:45 PM	eet down the hall befor it. He/She walked with rate pace. During the vere in the area.	a					
	On 8/7/14 at 1:45 PM, observation revealed the resident in the dining room independently moving dining chairs around. Further observation revealed his/her walker was near the table but							
	he/she did not use it while moving chairs. During the observation no staff were in the area.							
	On 8/7/14 at 4:20 PM, Administrative Nurse A stated the resident was independent with ambulation in his/her room prior to his/her fall on 7/6/14. He/she stated the resident was still oriented enough to know what he/she was doing, but his/her safety inhibitions were declining. He/She stated the staff do not update the care plan with every fall and only update when a new fall intervention is needed. Administrative Nurse A verified the interventions for falls on 3 occasions were already on the care plan. He/she stated after a fall, the nurse's are to update the care plans and stated the nurses and nurse aides review the care plan in the computer.							
	procedure directed th	fall assessment policy are staff to complete the potential cause of the facent's care plan.	post					
	effective interventions	evelop and implement s to prevent further falls operienced multiple falls						

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F 280	- Resident #9's annu 3.0 assessment, date resident understood/u had adequate vision von the (BIMS) Brief In which indicated mode. The MDS indicated the assistance of 1 staff f. grooming, the resident times during transition functional limitations i. MDS indicated the reswalker and had one n. assessment. The 5/14/14 quarterly except the resident haboth upper extremities prior assessment. The 2/27/14 (CAAs) C. summary for falls indicated and vertice with the common transition of the summary for falls indicated and vertice with the staff to provide the resident vencourage him/her to prevent slipping. The staff to provide the resident resident resident to provide the resident resident resident to provide the resident resident to provide the resident resident resident provide the resident residen	al (MDS) Minimum Date of 2/26/14, indicated the usually understands oth with glasses, and score of the resident required limit for dressing, toileting, of the same of the resident required limit for dressing, toileting, of the same of the resident required limit for dressing, toileting, of the same of the resident required limit for dressing, toileting, of the same of the same of the resident was the same of the resident was a same of the resident was a history of falls. Seessment revealed the staff to with gripper socks and wear them at night to he care plan instructed the sident with a walker for room or hall and provides.	elers, do 11 us, on. ited at all had The aprior elert ds a melp elert	F 280	DETIGIENCITY			
	the staff found the res	PM, nurse's notes indicastident on the bathroom I of smeared blood und	floor,					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ PLAN OF CORRECTION IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 280	his/her head and a la resident's right forehed blood noted. The number of the valuation and the rephysician orders to coultram (pain medicat as needed, hold Couldays, do neurological protocol, not to cover needed, to remove an resident's Norco (nar resident received a Trinjection in the emergy of the T/10/14 post fall stated he/she had slip bathroom. The floor whose the the slacks and brief, pulled the post fall event in alert and oriented, into walker, and was wead on 8/6/14 at 7:25 AM resident ambulated whis/her room to the disteady gait. The resident and gripper socks. On 8/5/14 at 2:15 PM had not updated the transport of the staff had resident's care plan at 7/10/14.	rge contusion to the ead with a large amount se's note indicated the ne emergency room for sident returned with ne continue current medication), three times a day, madin (blood thinner) for the wound but dab as my drainage, and to hole cotic pain medication), oradol (pain medication)	staff w tions, and or 2 d the as	F 280			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SU	
AND LAN OF CONNECTION		IX.	A. BOILDING		COMILE	
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F 280 Continued From page the staff to update the r fall. The facility failed to rev plan for Resident # 9 w to the emergency room the staff to provide apprifurther falls. - Resident # 4's quarte Set 3.0 assessment, da (BIMS) Brief Interview f 2, which indicated seve The MDS indicated the staff assistance with his Daily Living, including e swallowing problems. The 12/18/13 nutrition (Assessment indicated the problems, swallowing described ADLs and loss of arm in the 5/28/14 care plan from the serving. The care plan is hold a plastic sippy cup a pitcher, and the staff was within his/her react and a straw in it, when this/her room. The staff devices as needed inclusion a colored lip. The 7/14/14 physician of to provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray in the staff of the provide nectar consist foods with meals and stray	resident's care plan at riew and revised the corho had a fall and was a for evaluation, to direct ropriate care to prevent for Mental Status scorere cognitive impairment resident required total scher (ADLs) Activities eating, and had no (CAA) Care Area the resident had nutrit difficulties, a decline in movement. For nutrition/hydration rovide nectar thickense eliquids just prior to stated the resident copy with 2 handles instead were to ensure the pith, with thickened Gate the resident was along were to provide adapt uding a divided plate orders instructed the estency fluids and finger	are sent ect int Data d a re of ent. al sof ded ould ed ftcher orade e in tive with	F 280	DEFICIENC		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C	X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 280	Continued From page	e 13		F 280			
	On 8/5/14 at 12:55 PM observation revealed the staff provided total assistance to the resident who did not attempt to eat or drink independently. On 8/6/14 at 7:49 AM observation revealed the staff served the resident food on a regular plate.						
		evealed the staff remove then served the resider ivided plate.					
	On 8/6/14 at 12:53 PM, Nurse Aide A stated the resident was totally dependent on the staff for all cares and had not been able to feed him/herself for 2-3 months. On 8/7/14 at 4:58 PM Administrative Nurse F verified the staff provided total assistance to the resident with meals and fluids and no longer required a divided plate or sippy cups, however, the care plan did not reflect the resident's current needs.		or all				
			the ver,				
	plan to ensure the sta regarding the level of	e facility failed to revise Resident #4's care in to ensure the staff were knowledgeable arding the level of assistance, and assistive rices, the resident required with ing/drinking.					
F 281 SS=D		ICES PROVIDED MEE ANDARDS	Τ	F 281			
	•	d or arranged by the faction all standards of quality.	•				
	The facility had a cen sample included 17 re observation, record re facility failed to meet	not met as evidenced because of 34 residents. The sidents. Based on eview and interview the professional standards 7 sampled residents by	of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E183		B. WING		08/1	9/2014
	ROVIDER OR SUPPLIER		STREET ADDRI		ΓE, ZIP CODE		
GOVE CO	OUNTY MEDICAL CEN	ITER LTCU	PO BOX QUINTE	129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION) OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	leaving the resident's bedside, without wat medications. (#7) Findings included: - Resident #7's quar Set 3.0 assessment, scored 11 on the (BII Mental Status, which impairment. The MD no behaviors and recomedication. The 3/8/14 (CAAs) C summary, indicated to cognitive impairment no recent changes in medications. The 6/25/14 care pla administer antianxiet resident's behavior, a antianxiety medication adverse consequence. On 8/6/14 at 7:31 AN administration, observed the following medications bedside, then left the resident take his/her Aspirin, (a pain, fever milligrams Calcium 500 +D, (vit. Celebrex, (arthritis m. Colace, (stool soften Cozaar, (blood pressure)	terly (MDS) Minimum Dindicated the resident MS) Brief Interview for indicated severe cognist indicated the resident derived 7 days of a diured	tive had tic and the	F 281			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C		1 ' '	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	r.	A. Bollbino		COMPLE	ובט
		17E183		B. WING		08/1	9/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX				
	T		QUINTE	R, KS 6775			0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281	Continued From page	e 15		F 281			
1 231	Plavix, (antiplatelet m Prilosec Delayed Rele mg Senna, (laxative med Xanax, (anxiety medic On 8/6/14 at 7:31 AM administered the resid than other residents, this/her medications le his/her room. Nurse N take his/her medication a time, and the reside	edication) 85 mg ease, (ulcer medication ication) 8.6 mg cation) 0.25 mg (½ table), Nurse N stated the stated the resident wanted eft on the bedside table on slowly, one or two pient had requested to	et) aff ently, in ould	1 201			
	self-administer his/her medications. Review of the resident's medical record revealed the staff had not completed a self-administration medication assessment, or a care plan indicating the resident could safely self-administer his/her medications. Further review of the record revealed no physician orders for self-administration of medication.						
	had not care planned medications for the rethe nurses would do a assessment on a residirector of nursing wo upon admission to the resident would be cap of his/her medications On 8/7/14 at 4:58 PM verified a new resider admission to determine	dent. Nurse N stated the buld assess the resident of facility, to determine it bable of self-administrations. Administrative Nurse of the would be assessed une if the resident was	w if t f the tion				
	medication. Administr	administration of their rative Nurse A verified to assessed to redications and the s					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUI	
		17E183		B. WING		08/19/2014	
						06/1	9/2014
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX		20		
			QUINTE	R, KS 6775	92		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	Continued From page	e 16		F 281			
		he resident's care plan.					
		sility did not provide a p					
	The facility failed to assess Resident # 7 for safety of self-administration of his/her medications and failed to ensure appropriate administration of his/her medication.						
F 309 SS=D	9 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			F 309			
	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.						
	The facility had a cen sample included 17 re observation, interview	and record review the ughly assess the clinica	e				
	Findings included:						
	Resident #39 included (abnormal backward of Prostatic Hypertrophy prostate gland near the heart failure, hyperter chronic obstructive pure statement of the prostate gland of th	ne urinary tract), chronionsion (high blood pressollmonary disease (affects), Parkinson's disease	eflux gn c ure), cts air				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETI	
		17E183		B. WING		08/19	9/2014
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STAT	TE, ZIP CODE		
GOVE CO	OUNTY MEDICAL CEN	NTER LTCU	PO BOX QUINTE	129 R, KS 6775	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	pneumonia (infection The admission (MDS assessment, dated 6 had short/long term impaired decision machanges. The MDS irequired total staff as Activities of Daily Livinches and weight 1 indicated the resider altered diet and antit the look back period The 6/23/14 (CAA) (Coutrition indicated the assistance with eating thickened liquids. The aspiration pneumonic caused by inhaling sometimental status, decreconcentrated urine, lips, dry mucous meconstipation, fever, in imbalance), docume physician as needed staff to assist the reshydration at every miliquids during cares, update for nutrition of honey thickened liquid eating and watch him swallowing problems the staff to ensure the and after eating/dr	n of the lungs). S) Minimum Data Set 3.6 S/23/14, indicated the rememory problems, severaking skills and acute mindicated the resident sesistance for (ADLs) ving, his/her height was 78 (#) pounds. The MDS of the received a mechanical pointic medication 7 days. Care Area Assessment for eresident needed total and required honey are resident currently had a (a lung infection poter solids into the lungs). The plan directed the start for dehydration (change assed urine output, poor skin turgor, dry, crambranes, sunken eyes, infection and/or electroly and the findings and notified. The care plan directed the staff to proving the system of the care plan instructive resident sat upright be a syste	sident rely ental 75 S Illy of or staff Intially ff to in acked te y the I the ide with ed	F 309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E183		B. WING		08/	19/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX	(129			
			QUINTE	R, KS 6775	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From page	e 18		F 309			
F 309	The 6/13/14 admission indicated the resident clear lung sounds, no swelling and no feeding indicated the resident thickened liquids and (intermittently empty to tube) the resident, date of the 6/13/14 physician administer Cipro (antiby mouth, twice daily pneumonia. The order provide the resident at Review of the medical assessment for the resident.	on nursing assessment had a pink, moist tong cough, no sputum, no ng tube. The assessment received a pureed diet staff were to straight cathe bladder using a cathily for 10 days. In sorder directed the stabiotic), 500 (mg) milligr for 6 days for a diagnoser also directed staff to a regular pureed diet. If record revealed no diesident, from 6/13/14 to be the resident returned	ent i with ath neter caff to rams, sis of	1 309			
	the resident's lung so skin was warm, pink a vital signs (temperaturespirations) all within. The nurse's notes from the resident ate and content are and content and had a four the resident continued diagnosis of pneumor. The 6/19/14 physician consultation and hone. The 6/21/14 at 3:45 Four the resident had a "railled" the skill was a "railled" the ski	m 6/14 to 6/19/14 indiced frank fluids slowly, cholone was amber to dark to the sindiced on antibiotics for a maia.	er nt's re, ated ked ea ated eech				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/C		` ′	LE CONSTRUCTION	(X3) DATE SU COMPLE	
	17E183		B. WING		08/1	9/2014
NAME OF DROUGER OR OURSUITS		CTDEET ADDE		TE ZID CODE	00/	0/2014
NAME OF PROVIDER OR SUPPLIER	D.LTOU			TE, ZIP CODE		
GOVE COUNTY MEDICAL CENTER	RLICU	PO BOX QUINTE	R, KS 6775	2		
PREFIX (EACH DEFICIENCY MUST BE	EMENT OF DEFICIENCIES E PRECEDED BY FULL REC IFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309 Continued From page 19 thickened liquids today a was reddish tinged, amb amount of mucous. The i contacted the physician i for the resident, but inclu the nurse informed the p "raspy" cough and poor i The 6/22/14 at 4:20 PM, the resident's lung sound clear), his/her skin was o he/she had a temperatur note indicated the reside requested the staff notify Further review of the me additional documentation the nurses assessed the The 6/23/14 physician's o obtain a chest x-ray, (CB and (CMP) complete me laboratory work for the re The 6/23/14 physician's o provide a high protein pu liquids for the resident. Further nurse's notes ind 6/23/14 at 3:53 PM, the r large amount of phlegm staff suctioned him/her a 6/24/14 at 1:15 AM, nurs per nasal cannula at 2 lit administered a respirator resident. The note indica and administered medica liquids. The note further i	and the resident's uriper colored with a fair note indicated the nuregarding another muded no documentationysician of the residentake. In nurse's note indicated were coarse (not clammy/warm, and re of 97 degrees. The ent's family member by the physician. Addical record revealed in from 6/14- 6/22/14 to resident's lung sour order directed the stack) complete blood esident. Forder directed the stack dicated the following: The ent's family member by the physician. Addical record revealed in form 6/14- 6/22/14 to resident's lung sour order directed the stack dicated the following: The ent's family member by the physician of the stack dicated the following: The ent's family member by the physician of the stack dicated the following: The ent's family member by the physician of the stack dicated the following: The ent's family member by the physician of the stack dicated the stack dicated the following: The ent's family member by the physician of the physici	rurse urse latter ion lent's ed d no l, that hds. laff to count aff to count caff to count caff to count dened caff to count dened caff to count dened d	F 309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		17E183		B. WING		08/19/2	2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE		TE, ZIP CODE		
GOVE CO	OUNTY MEDICAL CEN	TER LTCU	PO BOX QUINTER	129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	was unable to clear he the staff suctioned his indication the nurse a sounds. 6/24/14 at 5:34 PM, the swallow medications (abnormal lack of energy that it is a sound and appointment further indicated the moaned, and appeared the number of the note stated the stated the stated the stated the resident fluids due to swallow and the note assessed the resident the physician's appoind dehydration and pneuton the physician's appoind dehydration and pneuton the functional stated the resident that he/she was not sanything to eat or drift stated the physician of the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs are stated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs are stated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs. The dochad a cough, choked suctioned him/her sestated the resident's control to the lungs.	nis/her throat of phlegm m/her. The note lacked assessed the resident's the resident was unable this morning, was lethatergy) and hard to arous aff notified the physiciant for the resident. The resident rested in bed, ed uncomfortable at timestaff did not provide the the resident being unable lacked indication the nat's lung sounds during indicated the physiciant to the hospital directly intent with diagnoses umonia. admission history and esident came to the officiality nurses were concessed and the chest x-ray shallowing and did not lank today. The document was concerned about an and the chest x-ray shallowing and the nurses weral times. The document stated the reside on food and the nurses weral times. The document oxygen saturation was 0-100%) on room air, his (darker than normal), were extremely dry and debris caked onto the set or of of the mouth from the physician's assession.	lung to lirgic e. n and note les. ble to lirse the from of ce erned nave t lobe ent s lent 88% is/her d soft the	F 309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		l` ′	E CONSTRUCTION	(X3) DATE SU COMPLE	
		17E183		B. WING		08/	19/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ΓE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX QUINTEI	129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	pneumonia, (3) Parki (irritated), (4) dement (a condition that block hypernatremia (a greconcentration of sodi of 150. The docume admit the resident to administer antibiotics physician cautioned the about the resident's some the resident with several pneumonia. The docresident's sodium leveral has been hydrated at improved. On 7/17/14 at 9:40 A resident in bed with the approximately 30 degrevealed Nurse A admitted the resident's control of the physician midafternoon. He/shet to the physician midafternoon. He/shet to the physician midafter of the resident in the physician midafter of the physician of the ph	nson's disease exacertatia, (5) obstructive uropaks the flow of urine), (6 ater than normal um in the blood) with sont stated the plan was to the hospital, start fluids the resident's family meserious condition. admission to swing becaused the hospital admere dehydration and bilecument indicated the relicament of the resident's family meserious condition. My observation revealed the relicame down, the resident his/her cognitive start and his/her cognitive start and his/her cognitive start indicated medication is feeding tube. My Nurse G stated he/social and normally do not medicated staff did not medicated of fluids, including and normally do not	athy odium osand the mber ditted ateral dent tus d the ion he adent pnitor fluids ration he g	F 309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SUR	
		17E183		B. WING		08/19/2	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1	
GOVE CO	UNTY MEDICAL CEN	TER LTCU	РО ВО	X 129			
			QUINTE	ER, KS 6775	32		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	Continued From pag	e 22		F 309			
	admission to the hosp re-occurrence of pneurosident had difficulty his/her Parkinson's dithe resident was alert re-admission to the hoverified the physician resident to the hospital pneumonia, but the dithe pneumonia. On 7/23/14 at 4:30 Pl facility had no further	oital (6/24/14) was a umonia or aspiration and clearing secretions due sease. Physician H state within 12 hours of cospital on 6/24/14 and on call had re-admitted all with dehydration and ehydration was becaused. M. Nurse C verified the documentation of lungs.	e to ted d the se of				
	sounds for Resident #39. The facility's undated Physician Notification policy and procedure stated the nurse must make the appropriate assessments of the resident's condition prior to contacting the physician and must document the assessment. The facility failed to thoroughly assess the respiratory condition of Resident #39, who the facility identified as being at high risk for dehydration, aspiration and pneumonia when he/she developed signs and symptoms of possible respiration problems, including coarse lung sounds, raspy cough and poor intake which required re-admission to the hospital with a diagnosis of pneumonia.						
	daily living receives the		:0	F 312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SU		
ANDILANO	CONCECTION		ir.					
		17E183		B. WING		08/1	9/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX		•			
			QUINTE	R, KS 6775				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	This Requirement is The facility had a cen sample included 7 res (ADL's) Activities of Dobservation, interview facility failed to provid correctly thickened fluresidents. (# 4) Findings Included: - Resident # 4's quar Set 3.0 assessment, (BIMS) Brief Interview 2, which indicated set The resident required ADL's and unable to be maintain upper torso of The 10/23/14 ADL fur Assessment revealed hospitalized recently status, and required effor the majority of his/ The 3/5/14 care plan staff to provide 2 pers reposition the resident lew the elevate the resident lew wheelchair as tolerate all transfers. On 8/5/14 12:55 PM,	not met as evidenced be sus of 34 residents. The sidents with 3 reviewed baily Living. Based on w, and record review the le assistance for ADL's uids for 1 of 3 sampled terly (MDS) Minimum Edated 5/21/14, revealed of for Mental Status scorwere cognitive impairment total assistance with he balance him/herself to balance. Inction (CAA) Care Area If the resident had been with a decline in mental extensive to total assistation assistance and at every 2 hours. In orders instructed stafflegs, allow up in the ed, and provide a total I observation revealed the right in the wheelchair	of for sea and sea of and sea of sent. sis/her sea of sent. sis/her sea of sent. site of sent. site of sent. site of sent. sea of sent. site of sent. sea of sent. sea of sent. set of sent. sent sent sent sent sent sent sent sent	F 312	DEFICIENCY)			
	On 8/6/14 at 7:49 AM	l, observation revealed	the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		17E183		B. WING		08/19/	2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
GOVE CO	UNTY MEDICAL CEN	TER LTCU	РО ВОХ		_		
			QUINTE	R, KS 6775	<u> </u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312	Continued From page	e 24		F 312			
	resident at the dining room table with his/her feet slightly elevated in the wheelchair, legs dangling over the footboard, and not touching the base. On 8/6/14 at 4:04 PM, Nurse Aide P stated the resident was very stiff and difficult to work with, and added he/she could not stay upright in the wheelchair.		gling se.				
			ith,				
	resident did not maint	M, Nurse A verified the tain appropriate body d into the wheelchair si	ide.				
	devices to maintain R	rovide equipment and / lesident #4's proper bo ed in his/her wheelchair	dy				
F 314 SS=D	483.25(c) TREATMENT PREVENT/HEAL PRE			F 314			
	resident, the facility members the facility	hensive assessment of nust ensure that a resid without pressure sore:	ent				
	individual's clinical co they were unavoidabl	ssure sores unless the ndition demonstrates the; and a resident havin	g				
	•	res necessary treatmen lealing, prevent infection om developing.					
	The facility had a cen sample included 17 re reviewed for pressure observation, interview facility failed to provid services to prevent the	not met as evidenced be sus of 34 residents. The esidents of which 3 were eulcers. Based on and record review the de necessary treatment e development of pressents sampled for pressents	e re and sure				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Υ
		17E183		B. WING		08/19/20	014
	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX	(129 ER, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) COMPLETION DATE
F 314	Continued From pag	e 25		F 314			
	Findings included:						
	Data Set 3.0 assess indicated the residen memory problems, so making skills, and ac The MDS indicated the staff assistance for (A Living, including bed no (ROM) Range of Neight was 75 inches The MDS indicated the mechanically altered medication for 7 days. The MDS indicated the unhealed pressure ulpink projection of tiss healing) and skin bre	t had short/long term everely impaired decision ute mental status change resident required total ADLs) Activities of Daily mobility and transfers, I whotion limitations, his/he and weight 178 (#) pour resident received a diet and antibiotic sof the look back period he resident had a Stage locer, with granulation (so uses that form during wo akdown interventions wief for the bed and chair	on ges. al had er unds. d. e 1, oft				
	summary for pressur- resident was non-am assistance of two sta transfers. The summarequired total staff as and developed an op- admission to the facil the resident had a St (previously documen or abraised (scraped buttocks, received tre- with granulation tissue	ary stated the resident sistance with bed mobil en area on day 5 of his ity. The summary indica age 1 pressure ulcer ted as a Stage 2, open area on his/her right eatment, and showed he present.	/her ated area) ealing				
		re plan lacked intervent down. The 6/18/14 care					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	(X3) DATE SURVEY COMPLETED	
17E183 B. WING 08/19/	/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129		
QUINTER, KS 67752		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314 Continued From page 26 update indicated the resident at risk for skin breakdown, needed assistance with bed mobility, and had a Stage 2 ulcer to his/her right buttock. The 6/19/14 care plan update directed the staff to assist the resident with repositioning every 2 hours and keep pressure off his/her right buttock. The 6/13/14 admission skin assessment indicated the resident had no open areas or bilsters. The 6/14/14 Braden scale (a scale used to assess the potential for skin breakdown) indicated the resident was at high risk for skin breakdown with a score of 12 (10-12 indicated high risk), he/she had very limited mobility, and probable inadequate nutrition intake. The assessment indicated the resident frequently had moist skin and the linens must be changed every shift. The 6/18/14 at 5:57 PM, nurse's note indicated the resident had an open area, approximately 0.5 (cm) centimeters in diameter on his/her right buttock. The note further indicated the open area was a Stage 2 pressure ulcer with pink intact skin surrounding it, without drainage or odor. The staff notified the physician and applied an Alevyn (wound bandage) dressing per physician's order. The 6/18/14 physician's order directed the staff to apply an Alevyn dressing to the open area on the resident's right buttock until healed and obtain a Dietary Consult for an evaluation of the resident's nutritional status due to the development of a pressure sore. The physician's wound care orders did not indicate how often the staff were to change the dressing. Review of the medical record revealed no dietary		

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F 314	consultant assessment time of admission on The 6/19/14 Braden Sassessment indicated nutrition and intervent breakdown included pathe resident's chair ar nutrition, pressure uld dressings/medications. Review of the nurse's following: 6/19/14 at 3:10 AM- or dressing dry and intact 6/19/14 at 1:10 PM- prinformation to fax to the resident's ulcer. 6/19/14 at 3:12 PM- Are buttock was clean, dresident's ulcer. 6/20/14 at 3:45 PM- Are shearing, groin is redicted. 6/21/14 at 3:45 PM- Are open area on the righ and starting to granul. 6/21/14 at 4:16 PM- pris now a Stage 1, 0.5 granulation tissue in the no odor. 6/23/14 at 4:12 PM- granulation tissue in the coccyx removed and is intact in this area, a scar-like tissue surrous.	ant for the resident from 6/13/14 to 6/24/14. Scale score was 11 and a the resident had very attions to prevent skin pressure relieving deviced bed, repositioning, are care, and applications. In notes revealed the appenarea to right buttook of the dietician regarding the provided dietary manage the dietician regarding the dietician regarding the dietician regarding the provided dietary manage the dietician regarding the dietician regarding applied to buttook. The area is pattern, are sore to right but a continues to be really the center with no drain. The dietician regarding the dietician regarding on his/front replaced because salthough there is red	I the poor ses to ses t	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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F 314	Continued From page	e 28		F 314				
	resident in bed with th	ne HOB elevated rees. Further observati ninistered medication	ion					
	Nurse Aide Q provide	rther observation revea						
	verified neither the (R he/she had completed the resident, including needs, for the initial 6	AM, Dietary Manager E D) Registered Dieticiar d a nutritional assessm g his/her estimated fluid /13/14 admission to the naware of the physician	n nor ent of I					
	used the Braden scal- skin breakdown and t needs to be initiated t He/she stated the res assistance when he/s and the staff provided repositioning. Nurse in notify the dietary man	, Nurse N stated the ste to assess the potential hen further evaluate who prevent skin breakdo ident was still standing the was admitted on 6/2 assistance with N stated the staff are to ager if the Braden scalautritional evaluation or	al for nat wn. with 13/14					
	verified the resident hulcer 5 days after adm stated the resident's E resident was at high r repositioning program his/her chair. Adminis staff are to notify the He/She stated all the	, Administrative Nurse ad developed the presents in the facility. He araden scale indicated isk and the staff initiated and provided a gel pastrative Nurse A stated the RD of new admissions. facility's mattresses are different the staff in	sure e/she the ed a d in					

Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

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F 314	mattress until actual The facility's 11/8/13 preventive skin care all residents. At adm assessed by a nurse necessary interventic and care planned. The the facility have a pre Residents identified assessed by the care appropriate cushions chairs. Repositioning implemented as indic instructed to repositive to reposition themse. Assessment for resid include a physician a assessment for resid directed the staff to re check to see if additi needed, add interver the dietary manager, interventions can be physician of any Stage The facility failed to p services for Residen acquired, Stage 2 pr his/her admission to 483.25(g)(2) NG TRI RESTORE EATING	Wound Care policy star measures are to be use ission all residents are for potential skin risk, ons would be implement policy stated all beds essure relieving mattres as "at risk" would be explan team and the splaced in wheelchairs as schedules will be cated and the staff are on residents who are unlyes every 2 hours. Idents with wounds will assessment and a nutritilents with ulcers. The potential interventions are into to the care plan and conal interventions are into to the care plan, in if applicable, so dietary started and notify the ge 1, 2 or 3 pressure ulcer 5 days after the facility. EATMENT/SERVICES - SKILLS ehensive assessment or	ted ed for ted s in es. and nable ional blicy d notify / cer.	F 314			
		as been able to eat eno nce is not fed by naso g	- 1				

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F 322	tube unless the residemonstrates that usunavoidable; and (2) A resident who is gastrostomy tube retreatment and service pneumonia, diarrheametabolic abnormali	ge 30 dent 's clinical condition se of a naso gastric tube fed by a naso-gastric o ceives the appropriate ses to prevent aspiration a, vomiting, dehydration, ties, and nasal-pharynge e, if possible, normal eat	e was	F 322			
	The facility had a ce sample included 17 observation, intervie facility failed to provi water flushes between	w and record review the de the specified amount	t of				
	Data Set 3.0 assess indicated the resider memory problems, s making skill and acu indicated the resider assistance for (ADLs had no tube feeding altered diet, and recommended).	mission (MDS) Minimun ment, dated 6/23/14, at had short/long term everely impaired decision te mental changes. The at required total staff as) Activities of Daily Livir and received a mechanical eived antibiotic medicati	on MDS ng, ly ons 7				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE SI COMPLE	
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The 6/23/14 (CAA) Cara summary for nutrition in needed to be spoon fed honey thickened liquids he/she currently has as lung infection potentially into the lungs). The CAI indicated the resident reliquids, required total stand he/she was unable. The CAA summary furth was at high risk for dehy aspiration pneumonia. Tresident experienced a top of his/her dementia, he/she had a significant health status. The 7/16/14 care plan laresident had a feeding to the resident had a feeding to the resident's feeding tube. On 7/17/14 at 9:40 AM, resident in bed with the approximately 30 degree revealed Nurse L admir medication through the Nurse L provided a 30 con Arginaid (a supplement protein drink, then flush 30 cc of water. On 7/22/14 at 8:22 AM, Nurse J prepared and a resident, the following medication, the following medication the followi	re Area Assessment adicated the resident of by the staff and requisation pneumonia (as y caused by inhaling and summary for hydratequired honey thicker aff assistance with east to drink independent ther indicated the residuydration and had The summary stated to sudden acute illness, Parkinson's disease to deterioration in his/had acked indications the tube. The summary stated to sudden acute illness, Parkinson's disease to deterioration in his/had acked indications the tube. The summary stated to sudden acute illness to deterioration in his/had acked indications the tube. The summary stated to sudden acute illness to deterioration in his/had acked indications the tube. The summary stated to deterioration in his/had acked indications the tube. The summary stated to deterioration in his/had acked indications the tube. The summary stated to deterioration in his/had acked indications the tube. The summary stated to deterioration in his/had acked indications the tube. The summary stated to sudden acked indications the tube. The summary stated to sudden acked indications the tube. The summary for hydratic acked to summary stated to the resident indications the tube. The summary for hydratic acked to summary stated to the resident indications the tube. The summary for hydratic acked to summary stated to the resident indications the tube.	ated a solids tion ned ating ly. dent the on , and ner), 250 a the d the ated on ent, be. m with	F 322			

Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E183 B. WING 08/19/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129** QUINTER, KS 67752 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 322 Continued From page 32 F 322 feeding tube: Potassium (a necessary chemical component of diet) liquid, 15 (ml) milliliters. Lexapro (antidepressive), 10 (mg) milligrams, crushed. Protonix (gastric acid inhibitor), 40 mg, crushed. Parolodel (anti Parkinson medication), 2.5 mg, ½ tablet, crushed. Mirapex (anti Parkinson medication), 1 mg, crushed. Sinemet ((anti Parkinson medication), 25/250 mg, crushed. Macrobid (antibiotic), 100 mg, capsule, opened and mixed with other medications. Folic acid (vitamin), 800 mg, crushed. Aspirin (anti-inflammatory drug), 81 mg. Protein shot, 12 gram per 2.5 (oz.) ounce liquid. Arginaid, liquid 8 oz. Continued observation revealed Nurse J mixed the crushed pills in 30 cc water and mixed them into the liquid potassium. Observation revealed Nurse J used a 60cc syringe and a stethoscope to check the feeding tube placement, then he/she flushed the feeding tube with 30 cc water. Nurse J administered ½ of a can of Jevity 1.5 per gravity drip, then the crushed, mixed medications with the protein shot and the Arginaid through the feeding tube. Nurse J administered the other ½ of the can of Jevity, and then flushed with 30 cc water. Nurse J verified he/she did not flush with water before or after administering the medications and stated he/she normally did not provide a water flush before or after medications during the tube feedings. On 7/22/14 at 10:30 AM, Administrative Nurse A verified the staff are to flush the feeding tube with 30 cc of water before and after medication administration and flush with 15 cc of water between each medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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F 322	policy directed the stain the stomach, use a cc water to flow into the and after the feeding, water. The policy furth flush the feeding tube and after medication at 15 cc of water between The facility failed to use flushes prior to admin between each medicate the feeding tube, per Resident #39.	abdominal tube feeding aff to confirm tube place a 60 cc syringe and allow the tube to establish pat flush the tube with 30 cher stated the staff are to with 30 cc of water between each medication. se the appropriate water istration of medication administered throught for the facility's policy, for	ement w 30 tency, cc to fore n with	F 322				
	as is possible; and ea adequate supervision prevent accidents. This Requirement is The facility had a cen sample included 17 re observation, interview facility failed to provid intervention to preven residents reviewed fo to provide an environment.	sion/Devices are that the resident as free of accident haz ach resident receives and assistance device not met as evidenced b sus of 34 residents. The esidents. Based on and and record review the le adequate supervision of further falls for 1 of 5 or accidents (#32) and fa	es to py: e n and ailed	F 323				
	hazards for 11 cogniti	ively impaired, independ dentified by the staff, w	- 1					

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F 323	Findings included: Resident #32's and Set 3.0 assessment, resident had severely (BIMS) Brief interview 5. The MDS indicated moderately impaired had wandering and with elook back period, independent with (AE including walking and Range of Motion imp The resident's baland walking, he/she had scheduled pain mediantidepressive medic back period. The quarterly (MDS) assessment, dated 4 except a BIMS of 6, i mobility, transfers, wassistance with toilet was unsteady but he him/herself and had The 7/16/14 quarterly except BIMS 4, phys days, rejected care a MDS indicated the reassistance with dress bed mobility, transfer more non-injury falls, since the prior MDS, and diuretic medicati	aual (MDS) Minimum Dadated 2/5/14, indicated wimpaired cognition with for Mental Status scored the resident had vision, wore glasses are rebal behaviors 1-3 day. The resident was DLs) Activities of Daily Ld transfers, had no (RO airment and used a wallow was unsteady with 1 non-injury fall, received cations and antianxiety exations 7 days of the local Minimum Data Set 3.0 (23/14, indicated the sandependent with bed alking, but required limiting. The resident's bala was able to stabilized 1 non-injury fall. If MDS indicated the sand wandering 4-6 days esident required extensions, limited assistance is, walking, toileting, had 2 or more minor injury and received antidepresions 7 days.	the h a re of nd ys of diving M) lker. ed bk ame ted nce ze me -3 . The ve with d 2 or falls sssive	F 323			
	motory or land prior to	damission and had on	ic idii				

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F 323	this past quarter on 1 indicated the resident bathing but was othed. The 2/27/14 care plate provide a walker, and remind the resident to his/her falls for trends on and clean, ensure footwear and the environment of the env	in-13-14. The CAA for A trequired assistance who was fairly independent on for falls directed the sight light in his/her room on get up slowly, analyzes, ensure his/her eye glather resident wears proving the resident wears proving the total total the sident to toilet at least of the care plan. 5/8/14 - and to nap in his/her room 5/25/14 - ensure call light 1/14 update of the care plan. 5/8/14 - and to nap in his/her room 5/25/14 - ensure call light 1/14 update of the care plan. 5/8/14 - and to nap in his/her room 5/25/14 - ensure call light 1/14 update of cue the why was already on the care m/her to go to the dining 1/14 care plan for falls where the falls resulted in head are sisted care at times, now that the last the falls resulted in head are sisted care at times, now the had and needed extensive the plan of the last the la	ith t. taff to n, e asses per er. he once night m ht care ent's plan. g ass	F 323			

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F 323	The 2/3/14 Fall Risk resident at high risk indicated high risk). 18 and the 7/21/14 fthe resident 's risk for The 4/6/14 at 5:35 Pthe staff found the resident was able to denied pain and had The 4/8/14 at 2:48 Pthe staff found the rehis/her room in front could not recall how naked except for a Vfloor was dry but the damp. The staff note resident to dress and family. The note indicent intervention would be frequently and offer a The 5/6/14 at 9:38 Pthe resident slept on room and when the shim/her to sit up, the assistance, to the floencouraged the resident rest in the reclination. The 5/29/14 at 5:50 the staff found the retter floor, without injury was covered with a find the resident without injury.	score of 12 indicated the for falls. (10 or more The 4/29/14 fall risk score all risk score of 20 indicator falls was increasing. M, fall investigation indicated the floor in his and slipped in the urine report the events of the land injury. M, fall investigation indicated the events of the land injury. M, fall investigation indicated the floor of the recliner. The resingular hecklace is seat of the recliner was ad no injury, assisted the donotified the physician and the formal property of the recliner was add no tified the physician and the formal property assisted the donotified the physician and the formal property assisted the formal property assisted the donotified the physician and the formal property assisted the formal property assisted the formal property assisted the formal property assisted the donotified the physician and the formal property assisted the formal property as a prop	re of ated cated s/her lently . The fall, cated or in dent as The seand	F 323			

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F 323	summary indicated to sitting on floor next to extended outward. The resident was not wear and socks on and lated playing hide and sees cratches to the resimatched the top of the indicated the staff distand objects in the resident of the indicated at approximation of the floor by the left side of his/her (cm) centimeter skin and a 7 cm long laced head on the left side various small skin to the resident stated be drail, but there was the resident had recommended in the resident had recommended in the resident stated to the (ER) emergent assessed a subcutation the resident frequent the call light for transition.	I PM, fall investigation he staff found the reside to the closet with his/her the summary stated the taring pants but had shoughed and stated he/shock. The staff noted 3 dent's mid back which he recliner. The note scussed decreasing furrisident's room, with famings easier with his/her investigation summary mately 11:45 AM, Nurse in the floor with 2 pools of the bed and blood cover face. The resident had tear above his/her left everation near the top of him. The resident also had ars on his/her right hand he/she hit his/her head on the bedraweived Percocet (narcotic AM for hip pain. The staff transported the resident corrective actions and the physician heous (under the skin) blood) at the laceration stated corrective actions histering Percocet, checkly and encourage the use	legs es e was niture ly, so Aid H of ered d a 3 eye s/her d. on the iil. c pain ident ian iite. k on se of	F 323			
		and answered question 7 cm laceration to the to	II.				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 323	his/her head and a 2 bleeding. The scalp is palpation indicated a The 7/22/14 at 10:00 the staff found the reshis/her bathroom in fiskin tear to his/her mistated he/she hit his/skin tear was closed an ice pack. The note resident did not like a alarm would be appliable. On 8/5/14 at 12:36 President got up from a staff person went to him/her with ambulat his/her room. Further resident had scabbed and one pink colored cm long at the top of On 8/6/14 at 8:56 AN resident independent from the dining room then left his/her walk ambulated about 10 the/she went back for slight limp at a mode observation no staff of the sident in the dining dining chairs around. The resident in the dining dining chairs around. The resident in the dining dining chairs around. The observation no staff of the observation no staff	cm forehead laceration acceration was stapled a subcutaneous hemator. AM, nurse 's note indisident sitting on the floor ont of the toilet with a 3 id forehead. The reside her head on the floor arwith glue and staff apple further indicated the assistance and a personed. M, observation revealed the table independently on him/her and assisted ion from the dining roor observation revealed to areas on his/her foreh mark/scar, approximate his/her forehead. M, observation revealed the areas on his/her forehead. M, observation revealed the areas on his/her forehead. M, observation revealed the public restroom are there. The resident here the down the hall befor it. He/She walked with rate pace. During the were in the area. M, observation revealed room independently mere was near the table be while moving chairs. During the were was near the table be while moving chairs.	and ma. cated or in 3 cm ent end the ied end ely 3 elker and ad ee a a the oving out uring	F 323			

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F 323	, ,			F 323			
	7/6/14. He/she stated oriented enough to know this/her safety inhi He/She stated the state plan with every fall and fall intervention is new verified the intervention were already on the cafter a fall, the nurse's plans and stated the new review the care plan in the facility's 3/13/12 procedure directed the state of	room prior to his/her fathe resident was still now what he/she was dibitions were declining. If do not update the card only update when a reded. Administrative Nutrans for falls on 3 occasionare plan. He/she stated are to update the care nurses and nurse aides in the computer. fall assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the potential cause of the father was still assessment policy are staff to complete the cause of the father was staff to complete the cause of the father was staff to complete the cause of the father was staff to cause	oing, re new urse A ions d e				
	The facility failed to develop and implement effective interventions to prevent further falls for Resident #32, who experienced multiple falls in the past 4 months.						
	tour, observation in the following hazardous of cabinet under the action (1) Dawn power dissolute a label warning of (2) A 1 quart spray bottle of Scleaner) with a Keep warning on the label. (3) One 8 ounce bottle	M, during the initial factor activity room reveales themicals in an unlocked with room sink: obvent, 1 quart plastic both skin and eye irritant. The of 409 cleaner and Silks Alive (artificial plarout of Reach of Childre e of Novus 2 fine scratowarning to avoid contact.	d the ed ottle a 1 ottle nt ottle				

Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E183		B. WING		08/19/2014	
	OVIDER OR SUPPLIER DUNTY MEDICAL CE	ENTER LTCU	РО ВОХ	ESS, CITY, STAT (129 R, KS 6775		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO) TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE
F 323	eyes. Activity Staff H verified the chemical hazards were accessible at the time of the observation. On 8/4/14 at 9:27 AM, observation revealed, in the unlocked cabinet under the dining room sink, a 1 quart spray bottle of Total solution (disinfectant) with the warning label of hazardous to humans, animals, moderate eye irritation and keep out of reach of children and a 1 quart bottle of foaming hand wash with a keep out of reach of children label. Consultant Staff B verified the observation and stated the chemicals should not have been stored in the unlocked cabinet. The facility's undated Hazardous Chemical Storage policy stated all staff are to be involved in observing and identifying potential hazards in the environment and removing them for proper storage. Any item that has the warning of keep out of reach of children or eye irritant should be removed from the residents' environment.			F 323			
	of potential accider cognitively impaired	provide an environment the hazards for the facility's d, independently mobile fied by the staff, who resi	3 11				
F 325 SS=D				F 325			
	resident - (1) Maintains accep	cility must ensure that a ptable parameters of nutr dy weight and protein leve					

XT3L11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E183		B. WING		08/1	9/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX	K 129 ER, KS 6775	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 325	demonstrates that this (2) Receives a therap nutritional problem. This Requirement is The facility had a cen sample included 17 re observation, interview facility failed to provid to establish dietary no of 5 residents reviewed. - The 6/13/14 (POS) Resident #39 included: - The 6/13/14 (POS) Resident #39 included (abnormal backward: Prostatic Hypertrophy prostate gland near the heart failure, hyperter chronic obstructive puexchange in the lungs slowly progressive neighbour pneumonia (infection) Resident #39's admiss Set 3.0 assessment, resident had short/lor severely impaired decacute mental changes resident required total Activities of Daily Livilinches, and weight of indicated the resident altered diet, and had	not met as evidenced besus of 34 residents. The esidents. Based on and record review the le a nutritional assessment of for nutrition. (#39) Physician Order Sheet did diagnoses of gastric reflow), depression, Benig (enlargement of the ne urinary tract), chronical chairs of the side of the property of the side of the control of the side of the property of the side of the side of the side of the control of the side of the s	oy: e nent for reflux gn c ure), cts air (a Data d the ms, he DLs) 75 IDS	F 325			
	issues.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E183		B. WING		08/19/2014	
	OVIDER OR SUPPLIER DUNTY MEDICAL CE	NTER LTCU	РО ВОХ	ESS, CITY, STAT (129 ER, KS 67752			
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F 325	The 6/23/14 (CAA) nutrition indicated the assistance with eatithickened liquids. Taspiration pneumor caused by inhaling. The CAA for hydratic required honey thickened liquids and help pneumonia. The reseacute illness on top severe Parkinson's significant deteriora. The 6/13/14 initial cassess the resident mental status, decreased th	Care Area Assessment for resident required total ng and required honey the resident currently had it (a lung infection potents solids into the lungs). It is in indicated the resident kened liquids, and he/shependently. The CAA further that was at high risk for sident experienced a such of his/her dementia and disease and he/she had tion in his/her health startare plan directed the startare plan d	staff Intially It e was her Iden Iden Iden Iden Iden Iden Iden Iden	F 325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING	E CONSTRUCTION	(X3) DATE SI COMPLE				
		17E183		B. WING		08/19/2014			
	ROVIDER OR SUPPLIER DUNTY MEDICAL CE	NTER LTCU	РО ВОХ	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752					
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F 325	the resident ate and choked easily. The 6/19/14 physicic consultation and ho Review of the medicassessment for the 6/24/14, at which tir hospital with diagnor pneumonia. The 6/23/14 physici provide a high prote liquids for the resident was un this morning, was leenergy) and hard to staff notified the phyappointment for the indicated the resident appeared uncomfor stated the staff did due to the resident note further indicate resident to the hosp physician's appoint dehydration and pnotent for the medical record weighed 176.8 # (8) just prior to admissi staff did not obtain a resident when admit facility. The 6/24/14 hospital	d drank fluids slowly, and drank fluids slowly, and drank fluids slowly, and drank fluids slowly, and drank fluids as property thickened liquids cal record revealed no diversident, from 6/13/14 to me the resident returned ones of dehydration and dranks order directed the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with thickent. PM, nurse's note indicated the second pureed diet with the second pureed the se	eech etary to the taff to ened ted ons if ted er d, and fluids The d the	F 325					

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E183		B. WING		08/19/2014	
	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GOVE CC	OUNTY MEDICAL CEN	ITER LTCU	PO BOX QUINTE	X 129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLI	ETION	
F 325	today because the fath that he/she was not sanything to eat or dristated the physician dehydration, infection infiltrate (material) in of the lungs. The dochad a cough, choked suctioned him/her sestated the resident's (normal range was 9 skin color was dusky mucous membranes he/she had food and palate (separates the back of the mouth). included the following pneumonia, (3) Parki (irritated), (4) dement (a condition that bloch hypernatremia (a greconcentration of sodi of 150. The docume admit the resident to administer antibiotics physician cautioned the about the resident's greveled Nurse Ladr through the resident's greveled Nurse Ladr through the resident's greveled a 30 cc wat supplement) mixed with sanything the session of the supplement	icility nurses were concesswallowing and did not have to and the chest x-ray shather resident's left lower cument stated the resident on food and the nurses veral times. The document oxygen saturation was 0-100%) on room air, his (darker than normal), were extremely dry and debris caked onto the set of the mouth from the physician's assessing: (1) dehydration (2) inson's disease exacerbitia, (5) obstructive uropals the flow of urine), (6) that the hospital, start fluids at the hospital, start fluids the resident's family megrave (serious) conditional record revealed the	nave it nowed it lobe ent is isent 88% is/her if soft the ment outed athy outed athy outed athy outed athe mber in.	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E183			B. WING		08/19/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	ITER LTCU	PO BOX QUINTEI	129 R, KS 6775	2		
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F 325	Continued From pag	je 45		F 325			
	verified neither the (F he/she had complete the resident, includin	AM, Dietary Manager C RD) Registered Dietician d a nutritional assessm g his/her estimated fluic 6/13/14 admission to the	n nor ent of				
	had called the physic morning, regarding the phlegm and no food/ went to the physician midafternoon. He/sho the resident's total in provided during care do not document inta monitored for signs a	M, Nurse N stated he/s cian on 6/24/14 in the ne resident's choking or fluid intake and the residual appointment in the stated staff did not mostake of fluids, including, during June and normalike. He/she stated the stand symptoms of dehydhall cares and meals.	n dent onitor fluids ally staff				
	stated the admitting of care plan intervention needs of the resident had not updated the re-admitted the resid instructions for the rewhich would indicate nothing by mouth, has received tube feeding stated the facility did	M, Administrative Nurse nurse should initiate the ns related to the current to the current to the care plan when the facient with interventions of esident's nutritional status he/she was to receive and a feeding tube and gs. Administrative Nurse not have a nutrition pole	e initial : aff lity r us,				
	assessments for Res to the facility on a me required total staff as was then re-admitted diagnoses of dehydra facility failed to ensur	provide nutritional/hydra sident #39, who was add echanically altered diet, esistance with eating, ar I to the hospital with ation and hypernatremia re a thorough nutritional e resident was re-admit	nitted nd a. The				

[· /		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLI	
		17E183		B. WING		08	/19/2014
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	•	
	UNTY MEDICAL CEN	TER LTCU	PO BOX 129				
			QUINTE	ER, KS 67752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 325	Continued From pag	e 46		F 325			
	second time, to the facility with a feeding tube through which he/she received his/her total nutrition.						
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION			F 327			
	The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.						
	This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to provide and monitor sufficient fluid intake to maintain proper hydration and health for 2 of 3 residents sampled for hydration. (#39, who was admitted to the hospital with diagnoses of severe dehydration and hypernatremia (a greater than normal concentration of sodium in the blood) and #4 regarding fluid consistently.)						
	Resident #39 include (abnormal backward Prostatic Hypertrophy prostate gland near the heart failure, hyperter chronic obstructive prexchange in the lungs slow, progressive ner pneumonia (infection Resident #39's admis Set 3.0 assessment, resident had short/lor	he urinary tract), chroninsion (high blood pressulmonary disease (affects), Parkinson's disease ve disorder), and	reflux gn c ure), cts air (a Data d the ms,				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	
17E183 B. WING 08/19/201	014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129	
QUINTER, KS 67752	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE
F 327 Continued From page 47 acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, his/her height was 75 inches, and weight of 178 (#) pounds. The MDS indicated the resident received a mechanically altered diet, antibiotic medication 7 days of the look back period and (IV) intravenous medication. The 6/23/14 (CAA) Care Area Assessment for nutrition indicated the resident required total staff assistance with eating and required honey thickened liquids. The resident currently had aspiration pneumonia (a lung infection potentially caused by inhaling solids into the lungs). The CAA for hydration indicated the resident required honey thickened liquids, total staff assistance with eating/dinking. The CAA further indicated the resident was at high risk for dehydration and he/she had aspiration pneumonia. The resident experienced a sudden acute illness on top of his/her dementia and severe Parkinson's disease and he/she had a significant deterioration in his/her health status. The 6/13/14 initial care plan directed the staff to assess the resident for dehydration (change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection and/or electrotyte imbalance), document the findings and notify the physician as needed. The care plan indiged and indige acres. The 6/14/14 care plan update for nutrition directed the staff to provide honey thickened liquids, assist the resident with eating/dinking at every meal and offer thickened liquids during cares. The 6/14/14 care plan update for nutrition directed the staff to provide honey thickened liquids, assist the resident with eating/dinking at every meal and offer thickened liquids during cares. The 6/14/14 care plan instructed the staff to assist the resident with eating and watch him/her for choking and swallowing problems. The care plan instructed the staff to ensure the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 ' '	E CONSTRUCTION	(X3) DATE SUR COMPLETI	
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F 327	resident sat upright eating/drinking and head of the bed eleventh of the following and no feed indicated the resident thickened liquids. The 6/13/14 physicial administer Cipro (arby mouth, twice dail pneumonia. The orprovide the resident Review of the medicassessment for the 6/24/14, at which tin hospital with the diapneumonia. The 6/13/14 at 11:00 the resident's lung skin was warm, pink vital signs (temperatives) all with the nurse's notes re 6/14/14 at 5:25 PM, fluids slowly, and che 6/16/14 at 4:57 AM, odor. 6/17/14 at 11:59 PM colored and had a for 6/18/14 at 12:08 AM dark tea color and he 6/19/14 at 3:12 AM,	before and after to keep the resident's (Havated.) ion nursing assessment in had a pink, moist tong to cough, no sputum, no ding tube. The assessment received a pureed die an's order directed the softibiotic), 500 (mg) milliging y for 6 days for a diagnoder also directed staff to a regular pureed diet. cal record revealed no die resident, from 6/13/14 to the the resident returned gnoses of dehydration and the resident and draward and dry and the resident ture, pulse, blood pressulin normal range. evealed the following: the resident ate and draward to deasily. The resident's urine was telled to the resident's urine was telled to the resident's urine was telled to the resident's urine was telled the resident telled the	ent t with taff to rams, sis of etary to the nd ated er nt's are, ank a foul a	F 327			

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(EACH DEFICIENCY MU	ST BE PRECEDED BY FULL RE	I .	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
continued on antibio pneumonia. The 6/19/14 (UA) Unindicated the resider greater than 1030 spis 1005-1030 and the concentrated the unity (an indicator of infect bacteria. The 6/19/14 physicial consultation and hore the following: 6/20/14 at 2:46 AM, dark yellow color and 6/21/14 at 3:45 PM, cough, no choking the taken a small amour and the resident's unamber colored with a note indicated the note indicated the note indicated the note included no docume the physician of the poor intake. 6/22/14 at 4:20 PM, were coarse (not clean clamy/warm, and in 197 degrees. The note family member requiphysician.	rinary Analysis lab work nt's urine had a value of pecific gravity (normal rate greater the value, the ne), negative for leukocytion) and positive for few an's order included a speney thickened liquids. The resident's urine was divided had a foul odor. The resident had a "rasphis shift, the resident had a form to of thickened liquids to rine was reddish tinged, a fair amount of mucous urse contacted the physicatter for the resident, but intation the nurse inform resident's "raspy" cough the resident's lung soundar), his/her skin was ne/she had a temperaturate indicated the resident ested the staff notify the an's order directed the s	more ytes y eech the a y'' dday . The ician it ed a and ds re of	F 327			
and (CMP) complete	e metabolic profile blood					
	Continued From parcontinued on antibio pneumonia. The 6/19/14 (UA) Unindicated the resider greater than 1030 spis 1005-1030 and the concentrated the uni (an indicator of infect bacteria. The 6/19/14 physicial consultation and hore following: 6/20/14 at 2:46 AM, dark yellow color and 6/21/14 at 3:45 PM, cough, no choking the taken a small amour and the resident's unamber colored with a note indicated the note indicated the note indicated the note included no docume the physician of the poor intake. 6/22/14 at 4:20 PM, were coarse (not cle clammy/warm, and the proposition of the poor intake). 6/23/14 physician of the poor intake. 6/23/14 physician of the poor intake. The 6/23/14 physician obtain a chest x-ray, and the standard physician.	OVIDER OR SUPPLIER UNTY MEDICAL CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION) Continued From page 49 continued on antibiotics for a diagnosis of pneumonia. The 6/19/14 (UA) Urinary Analysis lab work indicated the resident's urine had a value of greater than 1030 specific gravity (normal ra is 1005-1030 and the greater the value, the concentrated the urine), negative for leukocy (an indicator of infection) and positive for few bacteria. The 6/19/14 physician's order included a speconsultation and honey thickened liquids. Further review of the nurse's notes indicated following: 6/20/14 at 2:46 AM, the resident's urine was dark yellow color and had a foul odor. 6/21/14 at 3:45 PM, the resident had a "rasp cough, no choking this shift, the resident had a taken a small amount of thickened liquids to and the resident's urine was reddish tinged, amber colored with a fair amount of mucous note indicated the nurse contacted the physican of the resident's "raspy" cough poor intake. 6/22/14 at 4:20 PM, the resident's lung soun were coarse (not clear), his/her skin was clammy/warm, and he/she had a temperatur 97 degrees. The note indicated the resident family member requested the staff notify the physician. The 6/23/14 physician's order directed the sobtain a chest x-ray, (CBC) complete blood	OVIDER OR SUPPLIER UNTY MEDICAL CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 continued on antibiotics for a diagnosis of pneumonia. The 6/19/14 (UA) Urinary Analysis lab work indicated the resident's urine had a value of greater than 1030 specific gravity (normal range is 1005-1030 and the greater the value, the more concentrated the urine), negative for leukocytes (an indicator of infection) and positive for few bacteria. The 6/19/14 physician's order included a speech consultation and honey thickened liquids. Further review of the nurse's notes indicated the following: 6/20/14 at 2:46 AM, the resident's urine was a dark yellow color and had a foul odor. 6/21/14 at 3:45 PM, the resident had a "raspy" cough, no choking this shift, the resident had taken a small amount of thickened liquids today and the resident's urine was reddish tinged, amber colored with a fair amount of mucous. The note indicated the nurse contacted the physician regarding another matter for the resident, but included no documentation the nurse informed the physician of the resident's "raspy" cough and poor intake. 6/22/14 at 4:20 PM, the resident's lung sounds were coarse (not clear), his/her skin was clammy/warm, and he/she had a temperature of 97 degrees. The note indicated the resident's family member requested the staff notify the	OVIDER OR SUPPLIER UNTY MEDICAL CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 continued on antibiotics for a diagnosis of pneumonia. The 6/19/14 (UA) Urinary Analysis lab work indicated the resident's urine had a value of greater than 1030 specific gravity (normal range is 1005-1030 and the greater the value, the more concentrated the urine), negative for leukocytes (an indicator of infection) and positive for few bacteria. The 6/19/14 physician's order included a speech consultation and honey thickened liquids. 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ZIP CODE 17E183 STREET ADDRESS. CITY. STATE. ZIP CODE PO SOX 129 QUINTER, KS 67752 SUMMARY STATEMENT OF DEFICIENCIES CEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 49 continued on antibiotics for a diagnosis of pneumonia. The 6/19/14 (UA) Urinary Analysis lab work indicated the resident's urine had a value of greater than 1030 specific gravity (normal range is 1005-1030 and the greater the value, the more concentrated the urine), negative for leukocytes (an indicator of infection) and positive for few bacteria. The 6/19/14 physician's order included a speech consultation and honey thickened liquids today and the resident's urine was a dark yellow color and had a foul odor. 6/21/14 at 3:45 PM, the resident had a "raspy" cough, no choking this shift, the resident had taken a small amount of thickened liquids today and the resident's urine was reddish tinged, amber colored with a fair amount of mucous. The note indicated the nurse contacted the physician regarding another matter for the resident, but included no documentation the nurse informed the physician of the resident's "raspy" cough and poor intake. 6/22/14 at 4:20 PM, the resident's lung sounds were coarse (not clear), his/her skin was clammy/warm, and he/she had a temperature of 97 degrees. The note indicated the resident's family member requested the staff notify the physician.

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AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	K.	A. BUILDING		COMPLET	ED
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			QUINTE	R, KS 6775			
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F 327	Continued From page	e 50		F 327			
	laboratory work for the	e resident.					
	The 6/23/14 CMP (a till fluid and electrolyte by resident's sodium lever 137-145), (BUN) Blood indicator of inadequating 29 (normal range 9-20 manual of Diagnostic second edition, dehydroncentrate the BUN. The 6/23/14 physician provide a high protein liquids for the resident Further nurse's notes 6/23/14 at 3:53 PM, till large amount of phles staff suctioned him/he 6/24/14 at 1:15 AM, in per nasal cannula at 2 administered a respirate resident. The note included and administered medications and administered medications of the staff suctioned him (6/24/14 at 5:34 PM, till swallow medications of (abnormal lack of energia the staff suctioned staff	test to monitor and evaluations along the left at 150 (normal range od/Urea/Nitrogen (and the kidney function) level of the level of th	of description of the control of the				
	further indicated the r moaned, and appeare The note stated the s resident fluids due to		es. ole to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E183		B. WING		08/1	9/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GOVE CO	OUNTY MEDICAL CEN	TER LTCU	PO BOX QUINTE	129 R, KS 6775	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 327	admitted the resident the physician's appoid dehydration and pneion The medical record register to admission to obtain an admission ot obtain an admission ot obtain an admission ot obtain an admission of resimation for fluid necentimeters per kilogestimated daily fluid restimated daily fluid recentimeters per kilogestimated daily fluid recentification confiler and could be could be cause the fathat he/she was not stated the physician recentimeters anything to eat or dristated the physician recentimeters. The documentary because the fathat he/she was not stated the physician recentimeters per kilogestimated anything to eat or dristated the physician recentimeters.	to the hospital directly nament with diagnoses umonia. evealed the resident 36 kilograms) on 6/11/2 n to the facility. The station weight on the resident to the facility. The baseds, based on 30 (cc) ram, revealed the residenceds at 2410 cc. uid intake records from d:	ded ded ded ded ded ded ded ded	F 327			

Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED AND PLAN OF CORRECTION 17E183 B. WING 08/19/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129** QUINTER, KS 67752 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 327 F 327 Continued From page 52 stated the resident's oxygen saturation was 88% (normal range was 90-100%) on room air, his/her skin color was dusky (darker than normal). mucous membranes were extremely dry and he/she had food and debris caked onto the soft palate (separates the roof of the mouth from the back of the mouth). The physician's assessment included the following: (1) dehydration (2) pneumonia, (3) Parkinson's disease exacerbated (irritated), (4) dementia, (5) obstructive uropathy (a condition that blocks the flow of urine), (6) hypernatremia (a greater than normal concentration of sodium in the blood) with sodium of 150. The document stated the plan was to admit the resident to the hospital, start fluids and administer antibiotics. The document stated the physician cautioned the resident's family member about the resident's grave (serious) condition. The 6/27/14 hospital admission to swing bed history and physical stated the hospital admitted the resident with severe dehydration and bilateral pneumonia. The document indicated the resident's sodium level came down, the resident has been hydrated and his/her cognitive status improved. On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the HOB elevated approximately 30 degrees. Further observation revealed Nurse L administered medication through the resident's feeding tube. Nurse L provided a 30 cc water flush, 8 oz. of Arginaid (a supplement) mixed with a 12 gram protein drink, then flushed the feeding tube with 30 cc of water. On 7/21/14 at 11:45 AM, Dietary Manager C verified neither the (RD) Registered Dietician nor he/she had completed a nutritional assessment of the resident, including his/her estimated fluid

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1` ′	E CONSTRUCTION	(X3) DATE SI COMPLE	
		17E183		B. WING		08/	19/2014
	OVIDER OR SUPPLIER UNTY MEDICAL CEN	NTER LTCU	РО ВОХ	ESS, CITY, STAT . 129 R, KS 6775			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 327	needs, for the initial facility. On 7/21/14 at 2:10 F had called the physic morning, regarding t phlegm and no food, went to the physiciar afternoon. He/she st resident's total intake provided during care do not document into monitored for signs a and offered fluids with the care plan intervention needs of the resident had not updated the or instructions for the which would indicate nothing by mouth, has received tube feedin. On 7/22/14 at 5:45 F resident had a lot of diseases) and he/sh admission to the hos re-occurrence of pne Physician O stated to clearing secretions of disease, the resident re-admission to the hospi pneumonia, but the other pneumonia. He/s may have been conditioned.	PM, Nurse N stated he/s cian on 6/24/14 in the he resident's choking or fluid intake and the resin appointment in mid ated staff did not monitoe of fluids, including fluids, during June, and normake. He/she stated the stand symptoms of dehyd th all cares and meals. AM, Administrative Nurse nurse should initiate the ns related to the current at. He/She verified the state care plan with intervent the resident's nutritional state he/she was to receive and a feeding tube and	he nedent or the dissipation distribution di	F 327			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		17E183		B. WING		08/	19/2014
	ROVIDER OR SUPPLIER DUNTY MEDICAL CEI	NTER LTCU	РО ВОХ	ESS, CITY, STATE (129 (R, KS 67752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 327	would have been be the physician of the earlier and then the a UA earlier. The facility's 8/7/08 factors included fundit difficult for the resion communicate need (abnormal speech for (difficulty swallowing of possible insufficier and mucous membraturgor, thirst, dry movalues such as elevispecific gravity, signitemperature. The poto ensure residents adequate fluids as to dehydration. The facility's undate and procedure state to notify the physicial hours, within 24 houbusiness day includiced or respiratory in symptoms of a (UTI policy further stated and any time the nuwarranted physician so. The policy stated appropriate assess condition prior to comust document the conversation with the personnel in the characteristics.	etter if the staff had notification of the resident's complysician could have on the physician and the physician or clinic the physician that the physician or clinic the physician that the physician that the physician that the physician that the phys	risk make fluids ia signs skin lab ine evated staff eived for The sinext of The sive individual in the side in the	F 327			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SU	
AND I LAN O	CONNECTION		.1.			GOWII EE I	LD
		17E183		B. WING		08/1	9/2014
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX	K 129 ER, KS 6775	2		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 327				F 327			
		itted to the hospital witl tion and hypernatremia					
	Set 3.0 assessment, of (BIMS) Brief Interview 2, which indicated seven The resident required (ADLs) Activities of Denectar thickened fluid. The 10/23/13 Dehydra (CAA) Care Area Asseresident had a diagnor Failure (a condition w	ation/fluid Maintenance essment revealed the osis of Congestive Hear ith low heart output and sted with fluid) and was	d a re of ent. is/her d				
	decline in status and inectar thickened fluid prior to serving. The riplan directed staff to declarate the control of the cont	for nutrition revealed a instructed staff to provious and thicken the liquid esident low fluid intake offer fluids each time heart and at meal times.	s just care				
	provide Gatorade (a b sports drink designed carbohydrates and re	n orders instructed staff orand of noncarbonated to supply the body with place fluids and sodium nilk products, and necta	t n n lost				
		M, observation revealed ent water thickened to	d the				
	On 8/6/14 at 7:49 AM the resident water thic	, observed the staff, se ckened to pudding	rve				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
711121 27111 01	CONTRACTION					JOINI LETE		
		17E183		B. WING		08/19/	/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
GOVE CO	UNTY MEDICAL CEN	TER LTCU		OX 129				
			QUINTE	ER, KS 6775			0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 327	Continued From page consistency.	e 56		F 327				
		l, Administrative Nurse order the resident 's lidectar consistency.						
	The facility failed to the to nectar consistency	nicken Resident #4 's w at meal time.	ater					
F 329 SS=D		GIMEN IS FREE FROM UGS		F 329				
	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.		any J or quate					
	resident, the facility m who have not used ar given these drugs unl therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	ensive assessment of a nust ensure that resider ntipsychotic drugs are r less antipsychotic drug to treat a specific condi cumented in the clinical who use antipsychotic I dose reductions, and ons, unless clinically a effort to discontinue th	nts not ition					
		not met as evidenced b sus of 34 residents. Th esidents. Based on						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E183		B. WING		08/1	9/2014
NAME OF DD	OVIDED OD CUIDDUED	<u> </u>	STDEET ADDI	RESS, CITY, STA	TE ZID CODE		
	OVIDER OR SUPPLIER	TERLITOU			ile, zir cobe		
GOVE CO	UNTY MEDICAL CEN	IER LICU	PO BOX	K 129 ER, KS 6775	32		
			QUINTE	-K, K3 0773	9 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 57		F 329			
. 020	observation, interview facility failed to monitor ensure healthy bowel	and record review the or and provide treatmer	nt to	. 020			
	rindings included.						
	Set 3.0 assessment, or resident had cognitive Brief Interview for Me required extensive standressing, toileting, was bowel, and received a pain medication, anticomedications 7 days or The 5/21/14 care plar staff to assess the reseffectiveness of medications.	cations, monitor and re potension, and complain	d the MS) sfers, ent of ed d the				
	all listed constipation Aspirin (pain reliever) (antidepressive), Risp	following medications vas a side effect: , Lasix (diuretic), Sertraperdal (antipsychotic), vulsant), and Simvasta	aline				
	days). The record rev that the staff provided interventions or asses sounds.	el movements, for the ollowing dates: 7/20/14 (7 consecutive ealed no documentatio					

NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129 QUINTER, KS 67752 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided B. WING PO BOX 129 QUINTER, KS 67752 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 58 days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
GOVE COUNTY MEDICAL CENTER LTCU PO BOX 129 QUINTER, KS 67752 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided			17E183		B. WING		08/	19/2014
QUINTER, KS 67752 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided	GOVE CO	OUNTY MEDICAL CEN	TER LTCU			2		
days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION
(MOM) Milk of Magnesia (laxative) on 7/30/14 (7th day), without results. On 8/5/14 at 12:33 PM, observation revealed the resident seated at the dining table, fiddling with his/her clothing, with a slightly confused expression on his/her face. On 8/6/14 at 7:54 AM, observation revealed the resident ambulated with the staff to the dining room and the staff assisted him/her to sit in a dining chair. Further observation revealed Nurse J administered, to the resident, 5 medications, and the resident took the pills all at one time without problems. On 8/6/14 at 2:56 PM, Nurse Aide P stated the staff documented (BM) bowel movements in the computer. He/she stated, in June, the resident sometimes toileted independently and sometimes he/she was incontinent. Nurse Aide P stated the resident now required more assistance with toileting and transfers and the staff notified the nurse if the resident had no BM in 3 days. On 8/6/14 at 3:02 PM, Nurse J stated the staff are to give prune juice on the 4th day without a BM, and (MOM) Milk of Magnesia (laxative) per the bowel program on the 5th day. Nurse J verified the (MAR) Medication Administration Record indicated the staff provided no (PRN) as needed, bowel elimination interventions from 7/13/14 to 7/20/14. He/she verified the staff provided no PRN bowel elimination interventions from 7/13/14 to 7/20/14. He/she verified the staff provided no PRN bowel elimination interventions from 7/13/14 until 17/28/14 (day 5), without result, and on 7/30/14 (day 7) the staff administrated MOM, but no results were documented until 7/31/14.	F 329	days). The record reverse the staff provided pruintervention, without resident seated at the his/her clothing, with expression on his/her. On 8/6/14 at 7:54 AM resident ambulated we room and the staff as dining chair. Further of Jadministered, to the and the resident took without problems. On 8/6/14 at 2:56 PM staff documented (BM computer. He/she state sometimes toileted in he/she was incontined resident now required toileting and transfers nurse if the resident how the (MAR) Medication indicated the staff probowel elimination inter 7/20/14. He/she verif PRN bowel elimination until 7/28/14 (day 5), 7/30/14 (day 7) the staff probowel program on the staff probowel elimination until 7/28/14 (day 5), 7/30/14 (day 7) the staff probowel elimination until 7/28/14 (day	realed, on 7/28/14 (5th ne or apple juice as an results. The staff provide sia (laxative) on 7/30/1 ults. M, observation revealed dining table, fiddling was a slightly confused if face. I, observation revealed with the staff to the dining sisted him/her to sit in a observation revealed New resident, 5 medication the pills all at one time. I, Nurse Aide P stated to the pills all at one time and the staff notified the and the staff notified the and the staff notified the and no BM in 3 days. I, Nurse J stated the staff and the staff notified the staff provided no, (PRN) as new reventions from 7/13/14 fied the staff provided no in interventions from 7/13/14 without result, and on aff administered MOM, affind ministered MOM, affind the staff provided no, affind administered MOM, affind the staff provided no affind administered MOM, affind the staff provided no affind administered MOM,	ded 4 d the vith the g a urse as, he the ent times I the he aff are BM, he ied d d eded, to an according to a accor	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		1 1	LE CONSTRUCTION	(X3) DATE SUF	
		17E183		B. WING			
		171103		B. WING		08/1	9/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX				
			QUINTE	ER, KS 6775	52		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 59		F 329			
	computer program ale resident had no docu Nurse J stated, if aler bowel sounds, give p MOM the next day if t BM. He/she stated if t enema on the 3rd day also notify the physici On 8/7/14 at 4:45 PM stated the nurses are	I, Nurse N stated the facts the staff, on day 4, mented BM for 3 days. ted, the nurses are to crune juice, and follow with the resident has not had the nurse administers at y post alert, he/she would an. I, Administrative Nurse to implement the bowers of the state	if the check with d a lin lid				
	staff to implement the after 3 days without a Day #1 (day 4 without centimeters prune or Day #2 - Give 30 cc (the morning, if no BM administer a dulcolax still no BM. Day #3 - enema in the	t BM) - offer 120 (cc) co grape juice. MOM) Milk of Magnesia I the day before, and suppository in the even e morning, if bowels ha efore, and if no results,	en ubic a in ning if				
	The facility failed to minterventions to ensur elimination for Reside	re adequate bowel					
F 371 SS=D	483.35(i) FOOD PRO STORE/PREPARE/S			F 371			
	considered satisfacto authorities; and	sources approved or ry by Federal, State or stribute and serve food	local				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E183		B. WING	 	08/19/2014
	OVIDER OR SUPPLIER	TER LTCU	РО ВОХ			
			QUINTE	R, KS 6775	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 371	This Requirement is The facility had a cer sample included 17 robservations and integer serve food under sar onsite days in one of residents residing in Findings included: On 8/6/14 at 8:08 A Nurse Aide T approadining room table and #4, to assist him/her empty sugar packs a aide had held, rubber chair he/she was sear resident by tearing the with his/her hands. F Nurse Aide T did not	not met as evidenced because of 34 residents. The esidents. Based on erview the facility failed one dining rooms for the	to the 4 the 34 de 34 de sisted dent indled ior of the ed the alf aled use	F 371	DEFICIENCY)	
	aide should wash his soiling his/her hands when providing assis this included helping room and also stated he/she had touched this/her bare hands. On 8/7/14 at 4:58 PM	I, Nurse Aide T stated a /her hands before and a , and between residents tance. Nurse Aide T state the residents in the dini I he/she did not realize the resident 's toast with I, Administrative Nurse es needed to do proper	after s ated ng h			

Printed: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		17E183		B. WING 08/19/20			19/2014			
	OVIDER OR SUPPLIER	ITER LTCU	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	<u> </u>				
	QUINTER, KS 67752									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
F 371 F 431 SS=E	or providing assistan Upon request the factorizing staff to wash assisting a resident to the facility failed to exproper hand washing #4 to eat. 483.60(b), (d), (e) DF	o assisting a resident to ace for the residents. cility had no policy for the his/her hands prior to so eat. ensure the nursing staff g prior to assisting Residence.	e did	F 371						
	LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.									
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.									
	facility must store all locked compartments	State and Federal laws, drugs and biologicals in s under proper tempera only authorized personr eys.	n ture							
	permanently affixed of controlled drugs liste Comprehensive Drug	vide separately locked, compartments for storaged and in Schedule II of the g Abuse Prevention and and other drugs subject	- I							

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	17E183			B. WING		08/	19/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
	UNTY MEDICAL CEN	TER LTCU	РО ВО	X 129				
			QUINTE	ER, KS 6775	52			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From page	e 62		F 431				
	abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.							
	The facility had a cen sample included 17 re observation, record re facility failed to ensure not outdated for the 3 the facility, in 1 of 1 m medication carts. The	eview and interview, the estock medications we see stock medications we see residents, who resident and 1 estacility failed to ensure ined and defrosted to e	e re ed in of 2					
	Findings included:							
	observation of the me bottle of stock Aspirin 325 (mg) milligrams, v 3/2012. Also during the revealed a stock bottle Vitamin D (a vitamin s	4 and stock Aspirin, 81	one n), of on with					
	On 8/4/14 at 9:34 AM, Nurse I verified the expiration date on the Aspirin bottle.							
	On 8/4/14 at 9:55 AM, Nurse J verified the expiration dates on the Calcium and Aspirin bottles.							
		l, Administrative Nurse ere to check the resider						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E183			B. WING		08/19/2	08/19/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
	UNTY MEDICAL CEN	TER LTCU	РО ВО					
00.200				R, KS 6775	32			
24.0.15	OLIMANA DV. O	TATEMENT OF DEFIDIENCIES		1		FION	(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	COMPLETION DATE	
F 431	Continued From page	e 63		F 431				
	medications and the s							
	expiration dates wher	n giving the medication.						
	·	-						
	The facility did not protect the expiration of media	ovide a policy for monitications.	oring					
	The facility failed to o	nsure the stock medica	itions					
	were not outdated. Th		illoris					
		ial for receiving outdate	d					
	medications.	Ü						
	- On 8/4/14 at 9:33 A	M, during the initial tou	r,					
		edication room revealed	I the					
		of the refrigerator had						
	approximately 2 inche bottom shelf.	es of ice build-up on the						
	On 8/5/14 at 7:20 AM	I, observation revealed	the 2					
		ained in the freezer of t						
	refrigerator in the med							
	-							
		I, Nurse J verified the fr						
		eded to be defrosted. N	urse					
	J stated he/she was u	<u>-</u>						
	responsible for defros	oung the Heezel.						
	On 8/5/14 at 3:12 PM	I, Administrative Nurse	A					
		sure if any specific staf						
		sting the freezer in the						
	refrigerator in the medication room. Although requested, the facility failed to provide a policy for defrosting the freezer compartment of							
			t of					
	the refrigerator in the	medication room.						
	The facility failed to	naintain and defrect #1						
	freezer in the medical	naintain and defrost the						
		CONTROL, PREVENT		F 441				
SS=E	SPREAD, LINENS							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E183		B. WING		08/1	9/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	РО ВОХ	(129				
			QUINTE	R, KS 6775	2			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	Continued From page	e 64		F 441				
F 441	The facility must estal Infection Control Progsafe, sanitary and corto help prevent the detransmission of disease. (a) Infection Control For The facility must estal Program under which (1) Investigates, control in the facility; (2) Decides what progshould be applied to a (3) Maintains a record actions related to infection determines that a resiprevent the spread of isolate the resident. (2) The facility must program direct contact will transfer for the facility must program of the facility must program	blish and maintain an gram designed to provide infortable environment avelopment and see and infection. Program blish an Infection Contrait - rols, and prevents infection, and prevents infection individual resident; and of incidents and corrections. If of Infection in Control Program ident needs isolation to infection, the facility materials in the disease. In the disease is a sequire staff to wash the control to the control program is a sequire staff to wash the control program is a sequ	and rol stions fon, and ctive ust a ns od, if	F 441				
		le, store, process and to prevent the spread	of					
		not met as evidenced b sus of 34 residents. Th esidents. Based on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
17E183			B. WING		08/19/2014		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX	X 129 ER, KS 6775	2		
(X4) ID PREFIX TAG			GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	
F 441	facility failed to provide environment to prevent transmission of disease improperly storing nate residents who receive #37) and Resident #1 treatment mask). The facility failed to dwaste to help minimize of infections to the collocking the red bag done of the facility failed to distribute the properly by not adding disinfectant when clear the facility failed to distribute from the failed	eview, and interview, the a safe, sanitary int the development and se and infection by sal cannulas for 3 of the doxygen (#14, #33, ar 4's nebulizer (respirato de the potential transmis infect the whirlpool tulg the proper amount of aning the whirlpool. I'M, observation revealed cannula (nose piece of the resident's bed, him to the nebulizer machine ctive covering. I'M observation revealed are across the resident's ecovering, and Resident, uncovered, and lying machine. I'M observation revealed are covering, and Resident's ecovering, and resident's ecovering, and resident's ecovering and resident's ecovering and resident's ecovering and resident's ecovering and resident's	e 9 nd ry ssion ely b d f the is/her e, ne s bed nt	F 441			
	On orrina at 1.50 AM	, observation revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E183		B. WING		08/1	9/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
GOVE CO	OUNTY MEDICAL CEN	TER LTCU	PO BOX	K 129 ER, KS 6775	2			
(X4) ID	STIMMADA ST	TATEMENT OF DEFICIENCIES	QUILLE	1	PROVIDER'S PLAN OF CORREC	TION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
F 441	Continued From page	e 66		F 441				
	Resident #14 and #33's nasal cannulas were on the floor in front of the oxygen concentrator. Observation also revealed Resident #37's nasal cannula draped over the oxygen concentrator in his/her room and not bagged. On 8/7/14 at 7:52 AM, Administrative Nurse A							
		Id place the residents' s, when the residents'	nasal					
		e, to prevent contamina	ation					
	Upon request the facility provided no policy for the storage of the residents' nasal cannulas or nebulizer masks when not in use.							
	nebulizer masks in a	tore nasal cannulas and manner that prevents the esmission of disease ar # 14, #33, and #37.	ne					
	- On 8/6/14 at 10:15 AM, observation revealed the facility had one dumpster, outside the facility on the south side, labeled red bags only (indicating biohazardous waste) and was not securely locked.							
	the red bag dumpster red bagged items fror Staff E stated the san the red bag items, bu truck. Maintenance S	Maintenance Staff E stage was used to dispose on the facility. Maintenance trash company picket used a different trash taff E verified the red bacured in any way, and pof infection.	of the nce ed up					
	verified the aides put	, Administrative Nurse the red trash bags in the the facility, and he/she the dumpster.	ne red					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E183		B. WING		08/19	9/2014
	OVIDER OR SUPPLIER UNTY MEDICAL CEN	NTER LTCU	STREET ADDRI PO BOX QUINTE		,	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC IE		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	Continued From pag On 8/7/14 at 8:38 AM	ge 67 M, Housekeeping Staff F	:	F 441			
	stated, if a resident was in isolation, the housekeeping department placed the red trash bags, from the isolation room, in the red bag dumpster. On 8/7/14 at 9:12 AM, Nurse Aide G stated the resident whose trash was in a red bag was disposed of in the red bag dumpster.						
	Environment, Bureau stated medical waste containers, which are	e closable, constructed and to prevent leakage	t, to				
	I	cility provided no policy in the red bag dumpste lumpster.					
	dumpster, which con and/or any bodily flui	properly secure the red ntained the isolation tras id, or a contaminated ite al transmission of infect	h em, to				
	Nurse Aide S demond cleaning the whirlpool posted on the wall. Now whirlpool, filled the form to be supported in 2 ounces, Disinfectant, using a measurement, or 2 of the water. Nurse Aid to scrub the sides of solution to sit for 1 measurement.	•	ns e and nt with rush				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		CLIA ,		A. BUILDING		JRVEY ETED	
	17E183			B. WING		08/19/2014	
	OVIDER OR SUPPLIER		STREET ADDR		TE, ZIP CODE		
GOVE CO	UNTY MEDICAL CEN	TER LTCU	PO BOX QUINTE	129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID	I .	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	stated to drain the wavalve, and add 2 oun gallon of water added stated to start the wh water, and rinse. The to sanitize the surface surface with diluted son for 30 seconds an instructions indicated solution to each gallod dry on the surface of On 8/6/14 at 11:20 Al he/she cleaned the wadirections on the wall adding the 2 ounces well, and filled the whof water and then wa On 8/7/14 at 4:58 PM stated the facility had the whirlpool and the whirlpool room were whirlpool. Administratididn't think anyone I the new whirlpool or idirections were accurrenced.	ion for 3 minutes. In Disinfectant instruction ater fill to cover the intal ces of cleaner for each d. The instructions furth irlpool pump to circulate disinfectant cleaner state of the whirlpool, wipe solution and allow to rend air dry. The disinfect to add 2 ounces of the on of water and allow to the whirlpool for 10 minutes of the disinfectant in the hirlpool with several gall ited additional 3 minutes of the old tive Nurse A stated he/state with a clipton of the disinfectant in the hirlpool with several gall ited additional 3 minutes of the disinfectant in the hirlpool with several gall ited additional 3 minutes of the disinfectant in the hirlpool with several gall ited additional 3 minutes of the disease of the old tive Nurse A stated he/state with the directions to consider the posted cleaning rate. M, Administrative Nurse M,	er e the ated the nain ant air nutes. the after e foot dons is. A ning in the she clean	F 441	DEFICIENCY)		
	in the whirlpool room instructions on the bo disinfectant cleaner's adding 2 ounces of c disinfect the whirlpool	stated the staff should b leaner per gallon of wa	e e ter to				
	. To radility falled to d		~				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E183		B. WING		08	/19/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
GOVE CO	OUNTY MEDICAL CE	NTER LTCU	PO BOX QUINTE	129 R, KS 6775	2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	properly by not addidisinfectant when cl	ing the proper amount of eaning the whirlpool and tary environment to prev	ı	F 441			